California Department of Health Services

Medi-Cal Hospital/Uninsured Care Demonstration

Health Care Coverage Initiative

Request for Applications

Frequently Asked Questions

Table of Contents

Notes: 1. Senate Bill (SB) 1448 (Stats. 2006, ch. 76) was enacted to provide the statutory framework for the development and implementation of the Coverage Initiative by adding Part 3.5 (commencing with section 15900) to Division 9 of the Welfare and Institutions Code.

2. Responses to questions do not modify or limit the RFA or SB 1448.

General Information

1.	Can applications be submitted electronically or via fax?	No, CDHS will only accept hard copies of applications by mail or hand delivery as directed in the Addendum No.1 to the RFA (Addendum No.1), Application Submission. Fax or e-mail copies will not be accepted.
2.	May an applicant submit more than one application?	No, CDHS will accept only one application per applicant.
3.	Can the same applicant submit an application and also be named as a subcontractor or collaborator in another application?	Yes.
4.	How many copies of an application does CDHS require?	CDHS requires all applicants to submit an original and five copies of their applications.
5.	Does the 25 page limit include appendices?	No, the 25 page limit applies only to the body of the application. Any attachments other than those described in the Addendum No.1, General Instructions, will not be considered during the evaluation process. Attachments cannot be used as a mechanism to expand the 25-page application limit.
6.	Can an applicant include attachments in addition to those six listed in the RFA?	No, only those six attachments listed in the Addendum No.1, General Instructions, will be included in the evaluation process.
7.	Is there a font requirement for charts and graphs?	CDHS will accept charts and graphs in 8-point font, but would prefer 10-point font.
8.	Should the application be single or double spaced?	The 25-page application can be single-spaced or double-spaced in Arial 12-point font.
9.	What will be the composition of the evaluation committee?	The committee will be comprised of staff employed by CDHS and other individuals who are not affiliated with local governments or employed by CDHS.
10.	How large will the evaluation committee be? Will names be published?	The size of the evaluation committee will be determined by the number of applications received by CDHS. The Voluntary Letters of Intent submitted by prospective applicants will help CDHS determine the number of evaluators that will be needed. CDHS will not make the names of the evaluation committee members public until after the posting and notification of allocations.
11.	What if there are more "adequate" applications than funding available? How will CDHS decide which applicant to fund?	CDHS expects to receive more applications than there is funding available. After one applicant is selected from Northern and one from Southern California, as described in the Addendum No.1, Secondary Review and Analysis, CDHS will then allocate the remaining federal funding to at least three more of the highest ranking applications until all of the funding is allocated.
12.	Will the selection process rely solely on the highest scored applications or will the application content be considered as well?	Please see the Addendum No.1 for a description of the Technical Review and Secondary Review and Analysis process.
13.	Can additional information be provided after the application is submitted?	Additional information can only be provided if CDHS contacts an applicant to seek clarification on the information contained in an application. Responses to clarification requests must be submitted within two business days of receipt of the request.

14.	Will applicants receive verification of receipt of their application?	Yes
15.	What are the goals for this Coverage Initiative (CI)?	The goals of the Coverage Initiative include the expansion of health care coverage to eligible low-income uninsured individuals in California and achievement of the outcomes specified in Welfare and Institutions Code section 15903.
16.	What is the vision for this CI?	The vision of this CI is to reduce the number of Californians who lack health coverage. This will be accomplished by providing federal funding to local governments that have the unique ability to design health service delivery models that meet the needs of their diverse populations and build on local infrastructures.
17.	To what extent will the Centers for Medicare & Medicaid Services (CMS) be involved in the RFA process?	CMS will not be involved in the RFA process itself, but will review the potential selected applications to ensure that the proposed benefits and services are included under Title XIX of the Social Security Act. See also #21 below.
18.	Would our Board of Supervisors need to approve submission of our application?	Approval by a County Board of Supervisors may be a local requirement, but there is no requirement in SB 1448, the Special Terms and Conditions of the hospital financing waiver, or the RFA, that Board approval is needed.

Meaning of Terms and Phrases

19.	What is meant by “expand health care coverage”?	“Expand health care coverage” means to increase the number of eligible low-income, uninsured individuals who are provided health care services; to provide one or more new services; or, to purchase insurance for benefits.
20.	What is meant by “organized health care delivery system”?	An organized health care delivery system is a comprehensive, integrated network of providers who manage and deliver the benefits provided under each program.
21.	What is the definition of “health care services”?	Health care services means services (including dental and vision) and procedures for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease offered to eligible persons. The health care services may only include those services that would be available to the low-income, uninsured individual if the individual were eligible for services under the Medi-Cal program.
22.	Page 3, Item 7, defines “medical home.” It requires the primary care provider to maintain all of an eligible person’s medical information, and seems to assume that the primary provider would have all of the information. Page 13, item 3, also discusses “medical home.” Page 14, item 3(e) provides a different description of how medical information would be handled versus the definition. It is suggested that CDHS use this description [p. 14, Item 3(e)] and not the definition.	Refer to the Addendum No.1, Definitions.

23.	The definition of "medical home" on page 3 includes "licensed provider of health care services." Does this mean the individual provider or does this also mean the individual provider and the clinic where services would be provided? A governmental clinic is exempt from licensure.	Refer to the Addendum No.1, Definitions.
24.	Please define subcontractor.	Subcontractor means an entity or person that enters into an agreement with a selected applicant to provide one or more services to eligible persons enrolled in a selected applicant's health care coverage program, as part of the provider network, for which an allocation of federal funds has been made under the CI.

Application Content and Evaluation

25.	What would prevent an application from being reviewed/eliminated from further review?	Please see the Addendum No.1, Evaluation Process.
26.	What would be the determination of a failing element?	Please see the Addendum No.1, Evaluation Process.
27.	Please explain the references to "Medi-Cal beneficiaries" and "these beneficiaries" in Element 7.	Both "Medi-Cal beneficiaries" and "these beneficiaries" are references to Medi-Cal beneficiaries. In response to Element 7, applicants must explain the current provision of services to Medi-Cal beneficiaries as well as how the proposed health care coverage program will coordinate existing services to Medi-Cal beneficiaries (Welf. & Inst. Code, § 15905, subd.(o)).
28.	What documentation is required to fulfill the 11 elements for evaluation, support the applicant's ability to implement a program by September 1, 2007, and to use its allocation for each program year?	Please see the Addendum No.1, Elements for Evaluation**.**
29.	What documentation should be provided for Element 10?	Please see the Addendum No.1, Elements for Evaluation.
30.	What would be the determination of a passing element?	Please see the Addendum No.1, Evaluation Process.
31.	How will points be assigned in the technical review?	Please see the Addendum No.1, Technical Review.
32.	How will the final ranking of applications be determined?	Please see the Addendum No.1, Secondary Review and Analysis.
33.	Is there an objective scoring method for the final ranking, or will it depend solely on the evaluation committee's judgment?	The evaluation committee will objectively score the applications during the technical review and the secondary review and analysis process. The final ranking will be based on the final score from the secondary review and analysis.

34.	What will the evaluation committee's criteria be for the additional three points that can be added or subtracted?	Please see the Addendum No.1, Secondary Review and Analysis.
35.	Will CDHS use the same rating, scoring, and ranking process for an applicant who purchases health services for eligible persons rather than providing services directly?	Yes.
36.	There are six outcomes identified on page 12 of the RFA; how will these outcomes be evaluated in the evaluation process?	The use of the outcomes is described in the Addendum No.1, Required Outcomes.
37.	Could CDHS please give an example of how a program might meet the "sustainability" outcome (p. 12, Item 5)?	Please refer to the Addendum No.1, Required Outcomes.
38.	Item 3 of the Secondary Review and Analysis section (p. 17) suggests that more eligible persons being covered would be given a higher weight for efficiency and the cost per person services, than a program that might take a sicker population that is more expensive to cover. Would a program for frequent users or those who have chronic diseases be at a disadvantage because cost per patient would be higher?	Programs for frequent users, or those who have chronic diseases, will not be at a disadvantage because the cost per eligible person would be higher. The evaluation committee will take into consideration what each of the proposed programs is designed to do and the populations that will be served, and will evaluate the cost per eligible person on that basis.
39.	What is required to demonstrate how the health care coverage program will promote the viability of the existing safety net health care system?	An applicant must demonstrate that its network of providers include those in the local health care safety net system, including public and private disproportionate share hospitals, county clinics and community clinics.

Allocations

40.	Will there be any weighting of the applicant's other state funding sources? Would a county that is under-equity in its indigent care realignment funds receive added consideration?	Neither one of these factors will be considered.
41.	Are there any limitations in the manner in which the selected applicant can use the CI allocation?	Selected applicants can use the federal allocation to expand an existing program or develop a new program. If a program is expanded, selected applicants can either provide new benefits/services to persons currently receiving services, or increase the number of person receiving benefits services. Expenditures for expansion must be at least equal to the amount of federal funding received.

42.	Will the amount of funding be correlated with the number of indigent persons residing within an applicant's jurisdiction?	No.
43.	Can one program be allocated all of the federal funding?	No.
44.	What considerations will CDHS make to allocate no more than 30 percent of the annual allotment to a single entity? Is there a methodology or a range?	The 30 percent limitation is set forth in the SB 1448.
45.	How many applicants will receive allocations?	See the Addendum No.1, Number of Allocations.
46.	Is there a maximum dollar amount that can be requested, or a maximum funding amount?	No. Please see the Addendum No.1, Number of Allocations.
47.	What time frame will the allocations cover?	There will be a separate annual allocation for each program year beginning September 1, 2007, through August 31, 2010.
48.	What distinction is being made between "[not] reducing allocations to fund additional programs" and "[not] reducing allocations to maximize the number of funded applications"?	CDHS will not arbitrarily reduce allocations to fund additional programs. However, CDHS may reduce an applicant's requested allocation in order to fund at least the top five highest ranking applications. For example, if the total request for all five selected applicants is in excess of the available $180 million, CDHS must reduce the allocation to one or more of the selected applicants.
49.	Will funds remaining after the final reconciliation of all amounts due (claims) be available for payments of claims in the next project year?	No, federal funds that are available in a particular program year can only be paid for services provided in that particular program year. Therefore, it is critical that selected programs expend the funds necessary for CDHS to draw down the full amount allocated in a particular program year to ensure that all available federal funds are claimed.
50.	What will happen if the $180 million in federal funds is reduced?	CDHS does not expect the federal funding to be reduced.

Reallocation

51.	Why would CDHS reallocate funds?	Funds may be reallocated if the selected applicant: • Does not meet the expenditure schedule in a program year; • Fails to substantially comply with any of the terms of the contract; or • Terminates its contract with CDHS.
52.	Who may receive reallocated funds?	CDHS may reallocate funds to another initially-selected applicant, to another applicant who was not previously selected for funding, or to ensure that all available federal funds are claimed. Selected applicants receiving reallocated funds must demonstrate the ability to make the certified public expenditures necessary to claim the reallocated federal funds.

53.	If an applicant receives the maximum allowable allocation of 30 percent, would it preclude that applicant from receiving reallocated funds that may become available?	No.
54.	How will CDHS ensure that all available federal funds are claimed?	Refer to the responses under Expenditures Schedule of the FAQs.
55.	Should only the amount of funding for CPEs needed for the applicant's requested allocation be documented?	No, selected applicants should document all health care coverage program expenditures even if those expenditures exceed the amount needed to claim the full amount of the federal funds allocated to the selected applicant.

Administrative Costs

56.	Do selected applicants have to use the MAA Program to claim administrative expenses associated with the CI?	No. CDHS is developing an "Administrative Cost Claiming Protocol" that is currently under CMS review. The methodology described in the protocol will be used to claim administrative costs associated with the CI, rather than the Medi-Cal Administrative Activities (MAA) program, as initially specified in the RFA.
57.	What administrative costs, if any, are allowable?	CDHS is developing an "Administrative Cost Claiming Protocol" that is currently under CMS review. This Protocol sets forth the requirements for claiming the following administrative costs associated with the CI: 1. Health care coverage program outreach. 2. Development of screening and enrollment processes and systems. 3. Health care coverage program planning. 4. Enrollment of eligible low-income, uninsured persons into health care coverage programs. 5. Development and maintenance of data collection and quality monitoring systems. 6. Data collection and analyses for reports or surveys required by CDHS or CMS. 7. Costs of developing, monitoring and administering contracts or other arrangements with private and/or other public entities for delivery of services. 8. Operation of the Coverage Initiative administrative functions. 9. Care and case management of eligible low-income, uninsured individuals receiving health care coverage program services.
58.	Can CI funds be used for administrative costs/program administration?	No.
59.	Is CI funding available for Information technology (IT) or quality efforts? Would those activities be considered administrative costs?	Please see the response to question #57, above.
60.	What is the purpose of the MAA Program?	The MAA Program offers a way for Local Governmental Agencies (LGA) to obtain federal reimbursement for the cost of certain administrative activities necessary for the proper and efficient administration of the Medi-Cal program.

61.	What administrative costs can be claimed outside the Coverage Initiative under the MAA program?	None.
62.	Would transition costs into the program be allowed before September 2007?	Yes, the administrative cost claiming methodology currently under CMS review does allow for reimbursement of administrative costs associated with start-up activities (transition costs) beginning on March 1, 2007.
63.	Who can claim Medi-Cal Administrative Activities?	Please see the response to question #56, above.
64.	Will the Medi-Cal Operations Division help selected applicants get MAA claiming agreements, plans or amendments to these documents expedited and help speed up the cash flow for MAA costs before two years?	Please see the response to question # 56, above.
65.	Please provide examples of claiming agreements and amendments. How could these amendments impact the estimation of costs and reimbursements?	Please see the response to question # 56, above.
66.	Does the 17.79 percent reduction for non-emergency services to undocumented immigrants apply to MAA or other administrative process for the CI?	No. Please see the response to question # 56, above.
67.	In order for MAA costs to be claimed the enrollees must be Medi-Cal. Does CMS agree that these enrollees are all Title XIX Medi-Cal patients and would all be claimable?	Please see the response to question # 56, above.
68.	It is customary that funds for health plan premiums would include some administrative overhead. Would this approach be eliminated because of the administrative overhead?	No.
69.	What distinction does CDHS make between those case management, disease management and care management components of the program costs that are sometimes construed as administrative rather than direct patient care, and administrative costs that can be covered under MAA or another claiming plan?	To the extent that selected applicants include care and case management in their health care coverage programs, those costs will be claimed as administrative costs under the administrative claiming methodology currently under CMS review. Please see response to question # 57 above.

Application Requirements

70.	Does the application have to specify how the program will meet all six required outcomes?	Yes.
71.	What if the applicant does not currently provide health care services to Medi-Cal beneficiaries?	If the applicant does not currently provide health care services to Medi-Cal beneficiaries, the applicant would receive a "fail" for evaluation element #7 during the Pass-Fail Review step, and would be eliminated from the application evaluation process. Please see Welfare & Institutions Code, section 15905, subdivision (o).
72.	Will programs be required to give enrollees a choice in their assigned provider?	Yes, within the selected applicant's provider network
73.	Please provide an example of a response to the eleventh element.	Refer to Addendum No. 1, Elements for Evaluation.
74.	Please provide some direction for an acceptable response to element 4(c).	Refer Addendum No. 1, Elements for Evaluation.
75.	What should be included in the description of the eligible persons to be served annually for element 1(a)?	Refer to Addendum No. 1, Elements for Evaluation.
76.	Is a tracking and/or referral system required?	Yes, a system to track and record services provided to eligible individuals is required in element 2(c). A system to track referrals is not required but could be included.
77.	Is a Letter of Intent required to be submitted before the application is submitted?	Please see the changes to the timeline in the addendum for further information regarding submittal of an optional, Voluntary Letter of Intent.
78.	What are the allowed attachments and addenda? Are there any limitations on length?	The required attachments are identified on page 10 of the Addendum No. 1, Application Format. There is no restriction on page length to the required attachments. Any additional attachment or addendum submitted with an application, other than the required attachments, will not be considered in the evaluation of the application.

Additional Requirements

79.	With regard to the requirement that all network providers be reimbursed the same or similar amount for similar services (p. 10, #2), would the following be allowable? a) Prospective payment system (PPS) rates to federally qualified health centers (FQHC) (as network providers) include administrative costs. b) Many specialty care physicians require Medi-Cal Plus.	a) Yes, PPS rates to FQHCs would be allowable. b) Yes, Medi-Cal Plus payments to specialty care providers would be allowable. The legislative intent of this requirement is to ensure safety net providers are not disadvantaged by being paid much less than other providers for the same or similar service. It is not the intent of this requirement to change existing reimbursement methodologies for any provider types.
80.	Does every provider need to be paid at the same rate to meet the requirement for "same payments for similar services?"	No, please see the response to question #79, above.
80.	What documentation is required for the provider compensation at similar rates for similar services in the list of health care providers attachment?	This documentation could include a statement that all providers in the network will be reimbursed at the same or similar rates for similar services.

82.	If an applicant contracts with community clinics and reimbursement is made to all clinics at an identical rate, would it meet the requirement for compensation at the same or similar rates for similar services?	Yes.
83.	Would federally qualified health centers be excluded as a provider?	No.
84.	Does CDHS have a requirement that applicants partner with community health clinics?	No.
85.	Is a complete list of health care providers, including physicians and clinics for primary and specialty care required?	A complete list of all participating providers is not necessary. The list should provide an indication of the type and approximate number of providers participating. The type of provider should include whether the provider is a public safety-net provider, private safety-net provider, or other.

Health Care Services

86.	If our application had a clear description of what the interventions were, and what the infrastructure was to support those interventions, and who the individuals were and training they got, CDHS does not care what label we put on it, correct?	No. CDHS must be sure that the benefits and services being proposed are those that would otherwise be available to Medi-Cal beneficiaries if the low-income, uninsured individual were eligible for the Medi-Cal program. Therefore, the label is important, as well as the description of the service.
87.	With regard to case/care management, will CDHS be looking at services from the perspective of fiscal resource use or from an appropriateness of care perspective, or both?]	Both.
88.	Would CI funding be available for case and care management for indigent individuals who are homeless and who have various mental health issues?	Funding will be available for care and case management for indigent individuals who are homeless and who have various mental health issues; however, care and case management will be reimbursed as an administrative cost under the administrative cost claiming methodology, rather than as a health care service cost.
89.	Are there any particular restrictions on programs that provide services for people with substance abuse?	No, there are no particular restrictions on programs.
90.	Is that an eligible package of services to be covered?	Yes, substance abuse services would be an eligible package of services.
91.	Can CI funds be used for Healthy Kids premiums?	No.
92.	Would it be correct to say that CI allocations could be made for health care services that are not traditional face-to-face encounters, e.g., remote monitoring using telephonic communications for chronically ill eligible persons?	Yes, subject to CMS policy.
93.	Would emergency services be covered, e.g., in an area with high frequency of violence.	Nothing in SB 1448 prohibits reimbursement for this service. However, the emphasis of SB 1448 is on preventive services and primary care.

94.	Since the emphasis of CI allocations is on primary and preventive services, would retinal exams for individuals with diabetes be allowed?	Yes.
95.	What services can be included in the CI program?	Proposed benefits and services must be allowable under Medi-Cal and Title XIX of the Social Security Act.
96.	Do the Knox-Keene restrictions apply to the CI programs?	Knox-Keene would not apply to a coverage initiative program because the Knox-Keene Act regulates health care service plans that are licensed to provide health care services in exchange for a prepaid or periodic charge (e.g., Health Net, Blue Cross). However, if a government entity contracts with a licensed health care service plan to provide services to eligible low-income, uninsured persons under the coverage initiative, then that contractor would be licensed pursuant to Knox-Keene and would be required to follow the mandates of the Act.

Contract

97.	Will the contract be for the entire three-year period?	Yes.
98.	Will the regular state contracting process be used?	No, the CI agreements are exempt from the state contracting process.
99.	Will all contracts contain standard contract language?	Yes, where helpful to clarify standard terms in the CI agreement.
100.	When will contract amendments be required?	Amendments to the agreements may include but not be limited to: • Increases or decreases to the amount of allocation. • Substantial expansion or reductions to the CI program services; • Alterations or updates to the standard terms of the agreement.
101.	When might CDHS terminate the contract?	The reasons for termination of a CI agreement include but are not limited to the failure of a selected applicant, to substantially comply with any of the terms of the contract.

Allowable Costs

102.	Could an allowable cost include expanding a network or providing a provider directory?	Yes.
103.	Can CI funds be used to pay border-State providers (who are eligible to serve Medi-Cal beneficiaries) that render services to California residents?	CI funds can be used to pay border-State providers that render services to California residents. In order to render non-emergency services to eligible low-income persons enrolled in the CI program, these Border-State providers must be approved to serve Medi-Cal recipients.

104.	Why does the RFA specifically prohibit the use of federal funds for promotion or marketing activities while SB 1448 does not?	The Addendum No. 1, Use of Funds, did not include this language; however, SB 1448 prohibits using the $180 million in federal funds for administrative costs, and that would include promotion or marketing. Promotion or marketing activities can be reimbursed under the administrative cost claiming methodology currently under CMS review.
105.	What are allowable costs?	Allowable health care costs are those costs incurred by selected applicants for providing health care services that are within the definition of medical assistance in Section 1905(a) of the Social Security Act. Allowable administrative costs are those specified in the "Administrative Cost Claiming Protocol" currently under CMS review.
106.	What if an eligible person is enrolled but never receives services through the Health Care Coverage program?	If an eligible person is enrolled but never receives services under the health care coverage program, it would reduce the expenditures the selected applicant could claim and dilute the costs per patient served. If large numbers of enrollees are not served and expenditure levels drop significantly, CDHS may be required to reallocate funding to another CI program.
107.	If applicants have other forms of tracking eligible persons, would Coverage Initiative allocations pay for "an identification card system" as required in Element #1?	The CI allocations cannot be used for any administrative cost, including an identification card system. This is, however, something that could be reimbursed under the administrative cost claiming methodology currently under CMS review.

Reimbursement

108.	How soon can a program receive reimbursement?	Expenditures must be certified by selected applicants as having been incurred on and after September 1, 2007. The frequency of the reimbursements has not been determined; they could occur annually, quarterly, or at some other frequency.
109.	Can federal funds that are available in one program year be used to pay for services in another program year?	No, the STCs do not allow federal funds that are available in one program year to be used to pay for services provided in another program year; however, federal funds can be used to pay for services provided in a particular program year after the end of the program year.
110.	What services and benefits are allowable for reimbursement?	Those that would be available to low-income, uninsured individuals, if the individual were eligible for the Medi-Cal program.

111.	What will happen to funds not spent during a program year (September 1 through August 31) or if a program does not spend all of its allocated funds in a program year?	The funds for each of the three program years are annual allotments and are not available for use in subsequent program years, except to pay for services provided during the program year in which the federal funds are available. If a selected applicant does not spend all of its allocated funds in a program year, its funding may be reallocated as specified in SB 1448.
112.	Are expenditures for non-public providers of health care services eligible for reimbursement?	Yes.

Expenditures Schedule

113.	What is an expenditure schedule?	An expenditure schedule specifies when expenditures are expected to be made during the program year for providing health care services to low income, uninsured individuals under selected health care coverage programs. The schedules must specify expenditure levels on a quarterly and annual basis.
114.	Has CDHS determined what the expenditure schedule will be?	The expenditure schedule will be unique to each program and reflect the expenditures related to each health care coverage program. CHDS will work with each selected applicant to review and approve quarterly spending targets based on the program's structure.
115.	Can start-up or advance funds be requested?	Administrative costs related to starting up health care coverage programs such as, outreach, program development, or system development may be claimed using the administrative cost claiming methodology currently under CMS review.
116.	How will spending targets be determined?	The spending targets for each quarter will be based on each selected applicant's expenditure schedule.
117.	What is the purpose of spending targets?	The purpose of spending targets is to ensure all the federal funds allocated to a particular selected applicant can be claimed for services provided during the program year in which the federal funds are available.
118.	Can the funds that were not obligated, but that were apportioned in earlier time periods of the same fiscal year remain available?	Yes, funds remain available as long as selected applicants' incur costs by the end of the same program year.
119.	Please explain what would happen at the end of the second quarter with relation to the expenditure schedule.	At the end of the second quarter of each program year, CDHS will review the expenditure schedule of each selected applicant to determine whether expenditure targets have been met. If expenditure targets have not been met, CDHS will work with the selected applicants to determine whether there will be sufficient expenditures in subsequent quarters of the program year to draw down the entire allocation of federal funds, or whether some or all of the selected applicants' allocations must be reallocated, as specified by subdivision (j) of section 15904 of the Welfare & Institutions Code.

Certified Public Expenditures (CPEs)

120.	What reporting tool will be used for the CPEs?	CDHS will provide the claim and certification forms and instructions that successful applicants will use to certify expenditures for the services provided.
121.	What is a certified public expenditure?	A certified public expenditure is an expenditure that is "certified" by a governmental entity as having been made for reasonable and allowable costs that is subsequently reimbursed by the Federal Government at the appropriate Federal Medical Assistance Percentage. The expenditures incurred must be for eligible persons enrolled in the CI program receiving CI benefits/services.
122.	What will the CPE process be? Will it be based on estimates or actual costs? Will there be a certification form?	Selected applicants will submit quarterly and annual claims and certification forms to CDHS based on the actual costs incurred by the selected applicants for CI expenditures. CDHS will provide the claim and certification forms. CDHS will review and approve the certification and claim the federal funding, which subsequently will be paid to selected applicants.
123.	What is an example of how a CPE would work for a governmental entity?	As an example, a selected applicant incurs $100.00 in CI expense and certifies that amount to CDHS. On the basis of the certification, CDHS claims reimbursement from the Federal Government, which provides $50 dollars in reimbursement, or 50 percent of the cost incurred by the selected applicant.
124.	Since the amount certified must be reduced by a factor of 17.79 percent to allow for services to undocumented immigrants, if a program serves greater than 18 percent of undocumented immigrants will they be disqualified or suffer any negative effects?	The amount certified by selected applicants will no longer need to be reduced by 17.79 percent to allow for services to undocumented immigrants because of the recent federal policy change that will require selected applicants to verify citizenship and/or legal immigration status before enrolling low-income, uninsured individuals into health care coverage programs. Therefore, the scenario described in the question is no longer relevant.
125.	If an applicant can show that the population receiving benefits is 100 percent documented, will the 17.79 percent reduction still be applied?	No.
126.	Please clarify the issue about reducing expenditures by 17 percent?	Please see the response to question #124, above.
127.	If a county excludes undocumented immigrants, will they be docked any points? Is there any requirement to serve the undocumented immigrants?	Please see the response to question #124, above.
128.	We do not have county hospitals but only district hospitals – are their shared costs considered CPEs? The district hospital incurs the costs.	No, district hospitals cannot certify their costs to CDHS for subsequent claiming of federal funds. However, if a district hospital is a subcontractor to a county for providing services under a county CI program, the county could certify their costs to reimburse the district hospital.

129.	Can Expanded Access to Primary Care (EAPC) program funds be utilized as an appropriate source of local funds?	No, EAPC funds cannot be used as an appropriate source of local funds because the State actually incurs the cost when EAPC funds are provided by the State to local entities. There are no provisions in SB 1448 that would allow the State to claim for federal reimbursement based on these costs.
130.	Can realignment dollars and First 5 funds be used as CPEs?	Realignment dollars can be used as an appropriate source of the local funds, but First 5 funds cannot be used because those are earmarked by statute for a purpose other than the provision of health care services.
131.	Please provide as comprehensive a list as possible of allowable sources of local funds for the CI program.	The allowable local funds could include, but would not be limited to, the following: Maddy, realignment, CA Health Care for Indigents program, and Department of Motor Vehicles fees. These sources of local funds would be allowable to the extent that they are not otherwise obligated by statute for specific purposes.
132.	Page 5 [of the RFA] states that a grant that is being used for a specific purpose cannot be used for CPE. Would this apply to a grant that is already being used to provide health care services and that meets the MAA criteria?	Funding, such as a grant, that is currently received from a particular source that is specifically targeted for a specified purpose or program cannot be used as the non-federal share of funds for programs under the Coverage Initiative. However, those programs could be expanded by additional expenditures of non-federal funds. Then, applicants must clearly explain how their proposed health care coverage program will expand coverage options beyond those already received (if any) for individuals currently uninsured (see the Addendum No.1, Item 1(d) of the "Elements for Evaluation").
133.	When calculating CPEs, would selected applicants need to separate out the administrative costs from the direct care costs, since CI expenditures will be used to draw down federal funds for only direct care?	Yes, administrative costs will be claimed separately from direct health care costs. Therefore, each type of cost would need to be separately identified.
134.	Please give an example of how Medicare or Medi-Cal funds, which are revenue for providing patient care, could be used as a source of funds, and why this is not considered double-dipping. Also, does the State restrict the use of CI funds after they have been earned and reimbursed for CPEs?	The payments for services already provided are reimbursements. Once the payment is received by the applicant, the State does not track how that funding is used. It is considered a local expenditure, so it is not considered double-dipping. Basically, once payments are made and the reimbursements are received, the reimbursement can be used as the non-federal share by the county.

Budget

135.	How often will budgets be required to be submitted?	At least annually or when there are major budgetary changes.
136.	Do counties have to incur new baseline funding?	No. Counties do not have to incur new expenses above their current expenditure levels, but the federal funds received by selected applicants cannot supplant current local expenditures.

137.	How will the State enforce the specific dollar amount of baseline funding that an applicant agrees to?	Each agreement between CDHS and the selected applicant will include a provision that selected applicants' baseline funding will not decrease over the term of the agreement.
138.	If a county is already spending local funds to provide health care coverage to those who need it, would the county be able to use some of that local funding or can only new funding be used to draw down the federal allocation?	A county can use some of the local funding it is already spending for health care and claim federal funding that will be used for services for low-income, uninsured individuals under health care coverage programs. Also see answer to question #136.
139.	Is it necessary for a successful applicant to display all funding in addition to the CI funds that are needed for the health care coverage program?	CDHS has revised the budget forms and instructions. They are posted on the website at http://www.dhs.ca.gov/coverageinitiative.
140.	Are Intergovernmental transfers allowed?	No.
141.	Are only federal funds displayed in the budget?	CDHS has revised the budget forms and instructions. They are posted on the website at http://www.dhs.ca.gov/coverageinitiative.
142.	Should the budget include only the amount of expenditures expected to be reimbursed?	No, the budget should include all estimated expenditures that selected applicants believe will be made for health care services provided under the CI, not just those expected to be reimbursed. It would be beneficial to document all estimated expenditures even those above the requested allocation because programs eligible to receive reallocated funds must have the ability to expend the CPEs necessary to claim the reallocated federal funds.
143.	Should administrative costs be included in the budget even though the CI funds can't be used for administrative costs?	No, the budget should only include the estimated costs for health care services. Administrative costs will be reimbursed under the administrative cost claiming methodology currently under CMS review.
144.	Will CDHS consider a different budget level each year over the three-year period? If so, it may be more difficult to draw down the full allocation.	No, CDHS must have the same budget level over the three-year period even though it is expected that program costs will increase over the period due to inflation. This is necessary to ensure the entire federal allocation can be drawn down each program year.
145.	Is there a non-federal share requirement for applicants selected to receive funding?	Yes, each applicant selected to receive an allocation of federal funds must provide the necessary total funds expenditures using local funds in order to be reimbursed its allocation of federal funding. Additionally, the local funds utilized must not include other federal funds, or impermissible provider taxes or donations, as defined under section 1903(w) of the Social Security Act, and applicable federal regulations, but may include patient care revenue received from Medicare and Medicaid.

146.	Was the budget form intended for all types of eligible applicants?	The budget form was intended to be broad enough to be used by all applicants to identify costs associated with the proposed CI program, including subcontractor costs. The budget forms and instructions have been revised and they are posted on the website at http://www.dhs.ca.gov/coverageinitiative.
147.	The Budget Form may not be conducive to capturing the budgeted amount under a particular proposed program, e.g., similar to an insurance carrier that would calculate costs on a per member per month type basis. It is not readily apparent how costs would be documented. Also, how does the Budget Form relate to any claim and certification form that would be developed?	Based on comments received on the budget form, CDHS has revised the forms and posted it on the website at http://www.dhs.ca.gov/coverageinitiative. The budget form does not relate to the claim and certification form that will be used by selected applicants to certify their costs.
148.	Where would health treatment costs be reported on the budget template?	Please refer to the revised budget forms and instructions that are posted on the website at http://www.dhs.ca.gov/coverageinitiative.

Supplement/ Supplant

149.	How detailed does the selected applicant's fiscal system need to be?	It is very important that selected applicants maintain accurate financial records and other documentation that will enable CDHS or CMS staff to validate that federal funds are not supplanting local funds that otherwise would be used for health care services.
150.	Please define supplement/supplant.	The federal funds allocated to selected applicants must be in addition to of any county, city and county, health authority, State or federal funds that would otherwise be spent on health care services in that county, city and county, consortium or counties serving a region, or health authority. The federal funds must be used to create a new program or to expand an existing program. Welfare and Institutions Code section 15904, subdivision (k), requires that expenditures for expansion must be at least equal to the amount of federal funding received. This expansion could be accomplished by offering additional services, modifying current standards of eligibility, or purchasing health insurance for the target population.
151.	Does the "supplement not supplant" requirement mean that there is maintenance of effort requirement, that selected applicants have to expend a set amount of their services and that the federal allocation would supplement that?	Yes, the proposed CI program will expand coverage options beyond those already provided (if any) to individuals who are currently uninsured. Expenditures for expansion must be at least equal to the amount of federal funding received. Please see the response to question #150, above.

152.	How must the CI federal funds be used?	Federal funds allocated to selected applicants must reimburse the selected applicants for the benefits and services described in the Welfare and Institutions Code section 15904, subdivision (d). Once the reimbursement is received it can be used in any way a selected applicant deems appropriate, including using the funding for services under a CI program.
153.	In reference to supplement/supplant – are applicants required to create a new program or is expansion of an existing program permissible?	Selected applicants may use the federal allocation to create new health care coverage programs or expand existing health care coverage programs. If allocations are used to expand existing programs, the expansions should result in new benefits being provided to the same number of low-income, uninsured individuals or increases in the number of persons receiving these services.
154.	What funds may not be supplanted?	Please see the response to question #150, above.
155.	What are appropriate sources of local non-federal funds?	Any funds that do not include other federal funds, or impermissible provider taxes or donations, as defined under section 1903(w) of the Social Security Act, and applicable federal regulations. Funding, such as a grant, that is currently received from a particular source that is specifically targeted for a particular purpose or program cannot be used as the non-federal share of costs for programs under the CI. Federal funds received as revenue for providing patient care services can be used as non-federal share of expenditures.
156.	Can donations be used as a source of funds?	Yes, donations may be used as a source of funds providing they meet applicable federal requirements.
157.	What are some examples of when supplanting is presumed to occur?	If a selected applicant reduced the amount of local funds it usually expends and uses its federal reimbursement under the CI to "backfill" the local expenditures that would be considered supplanting.
158.	Does supplant only apply to the allocated federal funds?	Yes.
159.	Are there guidelines for dealing with the "supplement not supplant" provision in the law?	CDHS is not aware of any guidelines related to this issue.

Applicant Eligibility

160.	Which entities are eligible to apply for CI funds?	An applicant must be a county, a city and county, a consortium or more than one county, or a health authority.
161.	Will applicants working with Selective Provider Contracting Program hospitals or hospitals participating in the Disproportionate Share Hospital program have preference over all other applicants?	No.

162.	Can an individual hospital or hospital system apply?	No. An applicant must be a county, a city and county, a consortium or more than one county, or a health authority.
163.	Could an applicant partner with a county?	Yes, an applicant that is a county, city and county, consortium of counties, or health authority may partner with a county.

Enrollment of Eligible Persons

164.	Can eligible persons be enrolled prior to September, 1, 2007?	Yes, eligible persons may be enrolled in a health care coverage program, but reimbursement is only available for services provided to the eligible person on or after September 1, 2007.
165.	How do we expend all money in the last year of the CI when new enrollment is not allowed in the last six months?	Services could be increased for those already enrolled.
166.	Can eligible persons be enrolled during the last six months if they are notified that the coverage will terminate at the end of the CI?	No, it is not permitted under the STCs of the Demonstration.
167.	Would a person who has a medical need requirement be eligible? For example, would an eligible person who has a documented medical need prior to receiving care under a health care coverage program continue to be counted?	There is nothing in SB 1448 that would prohibit selected applicants from providing care to those with a documented medical need prior to receiving care under a health care coverage program.
168.	Are lawful immigrants excluded from the CI program?	An immigrant who is a lawful permanent resident continuously in the U.S. for at least five years is eligible for the CI program. Undocumented immigrants and lawful permanent residents without the five years of residence are not eligible for the CI program.
169.	Would undocumented immigrants who are already receiving restricted medical benefits be eligible to be enrolled in the CI program?	No. Undocumented immigrants will not be eligible to receive health care services under the CI. All selected applicants will be required to comply with the Deficit Reduction Act of 2005 and verify citizenship and identity prior enrolling low-income, uninsured individuals into health care coverage programs.
170.	What if an eligible person under a health care coverage program subsequently becomes eligible for Medi-Cal? What would happen to that individual?	The person would cease to be eligible to receive services under the CI and would, instead, receive services under the Medi-Cal program.
171.	If you have someone undocumented and enrolled in the program who becomes pregnant, they would then become eligible for limited scope Medi-Cal. Would these persons need to be screened for Medi-Cal to see if they are eligible?	Undocumented persons may not be enrolled in CI programs. Please see the response to question #169, above.

172.	Would it be permissible for eligible persons to be screened prior to enrollment, or would applicants need to wait until September 1, 2007? If so, is there a timeframe for screening to occur, e.g., July for September enrollment?	Screening low-income, uninsured persons to determine potential eligibility is an administrative activity for which CDHS is seeking CMS approval to begin reimbursement prior to September 1, 2007.
173.	Are there any guidelines on how frequently an eligible person, once enrolled, would need to be re-evaluated for eligibility? Would it be reasonable to use the Medi-Cal Healthy Family guidelines?	No guidelines have been developed on how frequently an eligible person, once enrolled, would need to be re-evaluated for eligibility. Yes, it would be reasonable to use the guidelines for the Medi-Cal program or Healthy Families program. The processes for eligibility determination and re-determination should be addressed in all applications as part of Evaluation Element #1.
174.	Are Medi-Cal beneficiaries with a share of cost (SOC) (which does not cover most services) eligible for enrollment in the CI program as an expansion of benefits?	No, Medi-Cal beneficiaries who have a SOC are ineligible because they already have eligibility under the Medi-Cal program.

Data/Reporting Requirements

175.	Is there a "typical" cost per uninsured or cost per unit of service?	No, there is no "typical" cost per uninsured or cost per unit of service.
176.	What data must be reported on an annual basis and at the end of the project?	CDHS has not finalized the list of data that must be reported; however, selected applicants will be required to report, at a minimum, the number of low-income, uninsured persons receiving services, the type of services provided, and the frequency of the services provided.
177.	What are the reports required to be submitted and their frequency?	While the specific reports have not been identified, reports must be submitted at least quarterly because that is the frequency with which CDHS is required to report to CMS on the progress of the CI.
178.	What are the requirements for the quality monitoring processes to be used by selected applicants to assess health care outcomes of eligible individuals enrolled in the program?	See the Addendum No. 1, Elements for Evaluation.

Target Population

177.	Is there a minimum or required number of individuals that a program must serve?	No, there is no minimum or required number of eligible, low-income uninsured individuals that must be served.
178.	What is the target population?	Applicants must define the target populations they will serve. The determinations could be based on trend data, needs assessment, the current body of literature or experience, etc.
179.	Is a needs assessment required?	No.
180.	Should a description of how the health care coverage program would offer geographic accessibility and culturally and linguistically appropriate services be included in the application?	Yes, if appropriate.

181.	Is a description required of how the partnerships, collaborations, or arrangements with other health care providers will meet the needs of the target population and provide adequate access, including access to culturally and linguistically appropriate services?	Yes, if appropriate.

CI Termination

182.	When will the CI end?	The CI is scheduled to end August 31, 2010, unless CMS approves the Demonstration for another five years.
183.	When will selected programs receive official notification of the end of the CI?	Selected applicants will be notified as soon as it is known whether CMS will approve a new Demonstration, or whether the Demonstration will be terminated.